Testimony of The Connecticut Dermatology and Dermatologic Society
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Supported by
The Connecticut Society of Eye Physicians and
The Connecticut ENT Society
Before the Public Health Committee on
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On House Bill 5446 An Act Concerning Standards in Contracts between Health Insurers and Physicians

Good Afternoon, Senator Handley, Representative Sayers and other distinguished members of this committee. For the record, my name is Tim Chartier, and I am a dermatologist practicing in Farmington. I am here representing over 95% of the Dermatologists practicing in Connecticut as an Executive Member of the Dermatology Society in support of Standards in Contracting between health insurers and physicians.

First and foremost we want to thank this committee for raising such a significant issue, one that my colleagues and I have been testifying on for seven long years. I have brought with me today some of that previous testimony for reference as tangible proof of our commitment to this issue. It is our hope that 2008 will be the year that justice prevails, giving physicians "real" contracts which can not be changed unilaterally in a contract period and with the complete fee schedules needed to make sound business decisions. In addition, physicians need assurance that the procedures they perform will be paid for. Specifically, physicians across the country are being taken advantage of by an industry practice known collectively as "bundling". Bundling is the industry practice of paying for one service only when a doctor has performed two distinct services on the same day. A General example of this egregious practice is when a patient comes in for a visit for shingles and in the course of the examination the physician discovers a lesion suspicious for skin cancer and removes it for a biopsy. He bills the insurer for the office visit (using an Evaluation and Management Exam code) and for the removal of a suspicious lesion, using another distinct CPT billing code. He also uses two distinct diagnostic codes and a modifier which is another two digit code, which tells the insurer that this exam and procedure are unrelated (standard CPT billing procedure). When the Explanation of Benefits comes back to the physician's office, only one code is paid. The insurance company may give an explanation like " related service" or "office visit payment included in

payment for procedure" or may give no explanation at all.

In the past physicians were often willing to absorb the loss, since internal appeal processes are arduous, time consuming, and in the end often cost more in physician and staff time than the unfairly denied payment. However, with reimbursements now so low, with the need to see twice as many patients in a day to cover overhead on top of the cost of trying to appeal the claim negating the partial reimbursement, physicians are forced to rebook any surgical procedure that is not critical in order to guarantee payment. Obviously there are problems with this type of health care system including the inconvenience for the patient, their loss of time and wages, their anxiety at having to delay certain procedures, excess copayments and the unnecessary filling of a slot in the physician's schedule that could be better utilized for another patient .

In 2006 fee schedule legislation was passed to provide physicians with fees for the top fifty codes most commonly used. Unfortunately, this is not enough to make sound business decisions. It also does little to confirm when a fee is reduced either by bundling, down-coding, or unilateral fee reductions during the contract period. There is also no physician protection against the insurance industry practice of automatically taking back money for an unlimited period of time, often two or three years later because they claim they have discovered they overpaid you in error. This inequity is highlighted by the fact that we as physicians have a limited time period, usually 45- 90 days, to file a claim or else forever forego payment. In addition, insurance companies often employ the tactic of withholding payment for review before denying claims, and then deny the appeal not on its merits, but because it wasn't filed in a timely fashion. We never get the whole picture. The 2006 legislation also called for a working group to meet twice a year on Standard in Contracting issues. Unfortunately, we have seen no relief from this working group or the partial fees that are now being provided.

Physicians, who have no bargaining power with the managed care industry, are forced to accept contracts with clauses that allow insurers to unilaterally change the terms of the contract, including the fees paid to a physician at any time with little or no notice in the contract period. Many of you have listened to the testimonies of my colleagues on the "bait and switch" tactics physicians incur with the managed care industry. This is where the physician is provided with a contract and promised fees to be provided for service, only to find out after signing the contract that the fees or

other terms of the contract are unilaterally changed by the HMO. Sometimes this happens in the first month of the contract, but often, it does not incur until four or five months into the contract period. For most physicians it is very difficult to terminate the contract at this time, even with a right to terminate in 30 days of a unilateral change clause. The administrative burden of changing appointments, copying records and sending out notification to these patients is costly and disruptive.

Many of us are beyond frustrated with these one-sided arrangements that detract from the patient/physician relationship and profoundly impact the healthcare delivery system in a negative way. We also see the lack of transparency and accountability by the industry who report high margins and low loss ratios (which are the healthcare expenses they pay out) and shamelessly pay outrageous compensation packages to their executives to keep profitability "respectable". How can physicians run their businesses blindfolded and in fear of terms which could significantly effect their bottom line? The answer is we can't. We need Standards that are fair and just and transparency by the industry to see just where all those premium dollars are really going.

In closing, we ask you to amend 5446 with language that calls for no unilateral changes, no bundling or down coding of services and full fee schedules. I have attached some preferred language for your consideration. I believe we all want to improve the healthcare system but we need to make some tough decisions before the system fails to deliver. .

Thank you for your time and consideration, and I will entertain any questions from members of this committee.

Section 1. (NEW) (*Effective January 1, 2009*) (a) As used in this section: (1) "Contracting health organization" means (A) a managed care organization, as defined in section 38a-478 of the general statutes, or (B) a preferred provider network, as defined in section 38a-479aa of the general statutes; and (2) "physician" means a physician or surgeon, chiropractor, podiatrist, psychologist or optometrist.

(b) No contract for services to be provided to residents of this state entered into, renewed, amended or modified on or after January 1, 2009, between a contracting health organization and a physician shall include any provision that (1) allows the contracting health organization to unilaterally change any term or provision of the contract, including, but not limited to, (A) fee schedules or provider panels, except on state or federal mandates, without a one year notice to the physician or (B) any right of the physician to discuss and negotiate the terms of any contract or the opportunity for the physician to terminate a contract before any amendment becomes effective, except that if the physician chooses to terminate the contract before such amendment becomes effective, such amendment shall not be binding on the physician during any period the physician's obligations continue under the contract,

(2) allows the contracting health organization to reduce the level of service coded or bundle same day services on distinct and billable services as one service for payment purposes, on a claim submitted by a physician without conducting a reasonable investigation based on all available medical records pertaining to the claim, or (3) delays payment beyond forty-five days after a claim is filed.

(3) **Provide an explanation of the physician payment methodology, the time periods for physician payments, and provide to each participating physician, prior to entering into the contract, a copy of the full fee schedule that determines the physician's reimbursement. It shall be permissible to require an agreement to keep the fee schedule confidential before releasing it to the physician. The time required to obtain this permission shall not be counted against any time limits on entering into or renewing the contract**